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	345268	A. BUILDING _____ B. WING _____	C 02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MARSHVILLE	311 W PHIFER STREET MARSHVILLE, NC 28103

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F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and observation, the facility failed to prevent the elopement of 1 (Resident #1) of 3 cognitively impaired sampled residents assessed to have exit seeking behavior. Findings included: A review of the 14 day Minimum Data Set (MDS) dated 1/5/16 revealed Resident #1 was severely cognitively impaired. Behaviors exhibited included verbal abuse towards others, rejection of care, wandering, hallucinations, and delusions. Resident #1 required limited assistance with activities of daily living (ADLs), had no limb impairment, and was able to ambulate without assistance. Active diagnoses included encephalopathy (a brain disease that alters brain function or structure), dementia with behaviors, anxiety, and hallucinations. A review of the care plans for Resident #1 dated 12/22/15 revealed care planning in place for a focus titled " Elopement Risk Needs-needs re-directing/distracting. Needs (brand name) bracelet related to (r/t) wandering. " The goals listed included " Resident will have no elopements through next review. " Interventions listed included " (brand name) bracelet	F 323	Past noncompliance: no plan of correction required.	2/12/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/12/2016

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placement and functioning every (Q) shift to left ankle Q shift. Start 12/25/15. "
A review of a nursing note dated 12/25/15 and timed 5:45 AM revealed, " Nurse stated she observed resident (Resident #1) at back door to therapy room. Seems as if resident was coming in, not sure. Resident was just standing at door. Unknown if she was coming in or just standing. Resident brought back to room. Resident due to wandering an ankle alarm applied to her right ankle and checked for working. NA assisted resident near door. Did not lock. "
A review of a nursing note dated 12/25/15 and timed 8:39 AM revealed, " Resident (Resident #1) noted with increased anxiety and keeps wandering around facility at this time. Resident states ' It just hurts my feelings. I ' m a doctor and nobody will believe me. I ' m just going to go. ' Resident keeps wandering down hallways toward exit doors and attempts to leave facility. Resident currently has (brand name) bracelet in place. "
A review of a nursing note dated 12/25/15 and timed 1:16 PM revealed Resident #1 attempted to leave the facility.
A review of a nursing note dated 12/25/15 and timed 10:17 PM revealed Resident #1 " opened 400 hall exit door " and " was shaking front lobby doors and punching in various numbers attempting to unlock the door. "
A review of a nursing note dated 12/26/15 and timed 7:52 AM revealed Resident #1 " states she is going home, pulls the fire alarm and alarms sounding. Resident (Resident #1) succeeded in getting directly outside of doors. "
A review of a nursing note dated 12/27/15 and timed 3:06 AM revealed the resident (Resident #1) was " heading to front lobby to go out. Stated she has to go home to her husband. "

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A review of a nursing note dated 1/4/16 and timed 2:06 AM revealed Resident #1 " attempted several times in leaving the facility. The note also revealed the (name brand) bracelet was in place on her left leg and worked properly. "
A review of a nursing note dated 1/4/16 and timed 11:47 AM revealed Resident #1 was transported to the emergency department by emergency medical services (EMS).
A review of a nursing note dated1/5/16 and timed 12:40 AM revealed Resident #1 was returned to the facility and sent to the emergency department for further evaluation.
A review of a nursing note dated 1/5/16 and timed 2:16 PM revealed, " Clarification 1/5/16 at 12:40 AM- Resident (Resident #1) returned to facility accompanied by police. Patient out of facility approximately 15 minutes. The (name brand) bracelet was not present when resident returned. "
A review of the investigation report by the local police department revealed a police officer was dispatched to a private residence at 12:08 AM on the morning of 1/5/16. The report read, in part, " On January 5, 2016 at approximately 0008hrs (12:08 AM) I was dispatched to (home address) in reference to someone knocking on the callers door and yelling. I arrived on scene and noticed a white elderly female on the door step at the caller home. While I was getting out of my car, she asked me if I lived there and told me she was cold. I asked her where she lived and she told me she stayed at Autumn Care. I asked her why she was not at Autumn Care and she told me that the nurses had given her some medicine and were being mean to her. I told her to come and get in my car and warm up and I would take her back to Autumn Care. I gave (Resident #1) a ride back and while talking to her, she grabbed my arm.

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Her hands were ice cold, possible to the point of frost bite. I advised the nurse when we got to Autumn Care and they advised that they were going to have her transported to the hospital for an evaluation. It is unclear how (Resident #1) was able to walk out of the facility unnoticed. " An attempt was made to interview the police officer without success.

A review of the outside temperature for the hours between 11:00 PM on 1/4/16 and 1:00 AM on 1/5/16 was completed on 2/4/16 at 3:40 PM. The temperature was reported to be 20 degrees Fahrenheit.

On 2/4/16 at 3:30 PM an observation was made of the distance from the facility door to the house where Resident #1 was discovered. The distance was 0.3 miles. The terrain was uneven and grassy with a paved driveway to the left of the grassy area. On the far left side of the driveway was a ravine. The house and grassy area was separated by trees and underbrush. The front yard of the house abutted a 2 lane road with a speed limit of 35 miles per hour (mph). An interview was attempted with the homeowner without success.

A review of the hospital record for Resident #1 on 1/5/16 revealed Resident #1 was admitted to the emergency department on 1/5/16 at 1:06 AM with an admitting diagnosis of hypothermia (an abnormally low body temperature) r/t environmental exposure. The record also revealed " The patient (Resident #1) apparently wandered outside for 20-30 minutes. Her rectal temperature is 97.0 degrees Fahrenheit (the average normal rectal temperature is 99.1 degrees Fahrenheit to 99.6 degrees Fahrenheit). She is mildly cool to touch. She will have passive warming put in place (blankets and increased warmth in the room), reassessed, and discharged

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back to the nursing home when normothermic (a temperature within normal range). " Resident #1 was discharged from the emergency department at 4:06 AM on 1/5/16 and returned to the facility.
An interview was conducted on 2/3/16 at 3:30 PM with NA #1. She stated if a resident exhibited exit seeking behaviors the staff watch them and try to redirect them, " especially if they are near an exit door. " She also stated the doors alarm if a resident with a (name brand) bracelet exits the facility, but the doors locked if a resident had on a (brand name) bracelet and walked within 10 feet of an exit door. She stated Resident #1 was sitting in the front lobby of the facility at 11:00 PM on 1/4/16.
An interview was conducted on 2/3/16 at 3:50 PM with Nurse #1. She stated the staff needed a physician order to place a (brand name) bracelet on a resident and it was requested if a cognitively impaired resident had attempted to leave the facility or exhibited exit seeking behavior such as " hanging around the exit doors. " . She also stated all exit doors in the facility were connected to the bracelet system and if a resident was wearing a (name brand) bracelet and approached an exit door, the door would lock, but there were no audible alarms. She further stated if a resident exited the facility without a (name brand) bracelet on the staff had no way of knowing they had exited.
An interview was conducted with NA #2 on 2/3/16 at 4:00 PM and revealed exit seeking behaviors included trying to go to the door, and trying to get out. If the resident was completely confused the nurse was informed. Confused residents who had exit seeking behaviors wore (name brand) bracelets and would set off an alarm on the door if a resident got too close. She described the alarm as " loud " and stated the door would lock

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too if a resident was too close.
An interview with the Direct of Nursing (DON) on 2/3/16 at 4:35 PM revealed Resident #1 was, " paranoid, delusional, aggrssive and exhibited exit seeking behaviors. She would say she wanted go home, she needed to get our of here, she said her husband wouldn't let her leave. I did not actually see her at the doors. When the staff saw her trying to exit they would redirect her with snacks, coloring, making cards, and spending a lot of time with the staff at the nurses station. She had a (brand name) bracelet on from the day of admission. If she was sent out to the emergency department we'd remove it. The (name brand) bracelet locks every door they come close to. Every one of our doors has a (name brand) bracelet safety on them. Every door should alarm and lock, even the main lobby door. The resident (Resident #1) exited the front door. She was not injured. The staff received a phone call from one of the houses in the neighborhood (directly in front of the facility). She was returned by the Marshville Police Department. The home owner called the police. The resident had on just a nightgown when she eloped. She didn ' t have on shoes or socks. "
An interview was conducted with Nurse #2 on 2/3/16 at 5:15 PM and revealed she worked 7AM-3PM on 1/4/16 and was the care nurse for Resident #1. She stated she removed the (name brand) bracelet at the request of EMS when they took Resident #1 to the hospital. Resident #1 returned to the facility at 3:30pm and Nurse #2 stated she had ' reported off ' to the 3PM-11PM nurse and had not replaced the (brand name) bracelet.
An interview was conducted with Nurse #3 on 2/3/16 at 5:20 PM and revealed she was the 3PM-11PM care nurse for Resident #1 on 1/4/16.

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She stated she did not take report from EMS when Resident #1 returned (about 3:30-4:00) but knew she was back because she saw her in the hallways. she did not replace the (name brand) bracelet because, "I was very busy. I was orienting a new nurse and this shift is a very busy shift." She further stated she was charting after her shift when Resident #1 was returned by the police. She said the resident was cold, but had not appeared to be injured. She stated when the local neighbor called the facility to say there was a lady in her yard hollering they suspected it was Resident #1 because, " She had attempted to exit the facility the night before she actually did elope. " Nurse #3 stated she was charting after her shift on 1/4/16 and saw Resident #1 attempting to leave through the front door. She followed her and was able to redirect her to her room. When Resident #1 eloped, this nurse stated it was through the front door. She was not sure how the resident got the code to unlock the doors because they are locked from 8 PM until morning a code was needed to enter or exit.
An interview was conducted on 2/4/16 at 11:30 AM with NA #4 and revealed Resident #1 went to the doors " a lot " , and always stated she needed to be somewhere. She also stated the doors locked if a resident with a (name brand) bracelet walked to close to an exit door.
An interview with Nurse #4 on 2/4/16 at 11:35 AM revealed Resident #1 always stated she wanted to leave,or was going to leave. Nurse #4 also stated she did notrecall Resident #1 going to the doors often during the day time. She also stated Resident #1 wore a (name brand) bracelet and was re-directed when she started 'threatening' to leave. The nurses had access to (name brand) bracelets and did not need an physician (MD) order to place one on a resident.

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An interview with the Quality Assurance Nurse on 2/4/16 at 11:40 AM revealed no MD order was needed to place a (name brand) bracelet. Anyone could physically place one on a resident, but it was up to licensed staff to assess the need for one. If a resident was being taken to the hospital by EMS the (name brand) bracelet was usually removed. When the resident was returned to the facility it was the responsibility of the nurse completing the return assessment to re-place the (name brand) bracelet on the resident. She stated that did not happen the night Resident #1 eloped.
An interview with the director of maintenance was conducted on 2/4/16 at 12:15 PM. He stated, " Door locks are checked weekly by the maintenance department. Restorative aides check them daily. That includes every exit door we have. Every exit door is connected to the (name brand) bracelet system. The front door locks from the inside and out at 8 PM, but there is a keypad to enter a code and override the lock. It unlocks at 6 AM. The staff called me the night the resident (Resident #1) eloped and told me she had gotten out. I came down and I checked the door. I couldn't find anything wrong with it. The door was locked when I got here. I called the company that installed the system and I had a tech come up to double check every exit door. He couldn't find anything wrong either. There is an override switch beside every keypad in the facility per state requirement. It is a clear plastic cover with a red light switch underneath it. If the cover were to be opened, a loud, a very loud squeel is heard. The squeel remains on as long as that box is opened. If a resident with a (name brand) bracelet on walks across the threshold of an exit door an alarm will sound, even if the lock has been overridden. As long as the doors remain closed, no audible alarm is heard, the doors just

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lock. Since the resident (Resident #1) didn't have a (name brand) bracelet, no audible alarm would have sounded. I remember her (Resident #1). She was confused at times and would talk in a paranoid way about the government monitoring her and such."

An interview was conducted on 2/4/16 at 12:40 PM with Nurse #5. She stated she last saw Resident #1 on 1/4/16 between 11:45 PM and 11:50 PM in the common area and had asked for something to drink.

An interview was conducted with Nurse #6 on 2/4/16 at 12:45 PM. She stated she worked 3 PM-11 PM on 1/4/16. She said the resident (Resident #1) exited out the front door, and that it was not locked the way it usually was when she arrived for work on 1/4/16 at 10:45 PM. She stated the staff discovered it would not lock automatically the way it was supposed to, but the staff did not know why. She stated they called the maintenance director at home and after 'awhile' here told them he had fixed it. She also stated when the resident (Resident #1) returned with the police she had not appeared injured, but she was sent to the emergency department " just in case. " Nurse #6 stated Resident #1 was wearing "a thin nightgown. That was it." She also stated it was really cold that night, but she doesn't know what the temperature was, just that "it was one of our colder nights." She stated Resident #1 was found across the street from the main entrance of the facility in a neighborhood yard. She does not recall seeing a (name brand) bracelet on the resident and was told Resident #1 had gotten out once before around Christmas, but "She was just walking around the yard."

An interview with NA #5 was conducted on 2/4/16 at 1:10 PM. She stated she was an NA on the 11PM-7 AM shift and also stated if a resident was

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discovered to be missing a "code yellow" is called overhead, but no Code Yellow was called that night.
An interview was conducted on 2/4/16 at 1:22 PM with Nurse #7. She stated she had known the resident (Resident #1) had eloped after she was returned. She also stated the resident had eloped out the front door and, " We had a problem with the front door locking that night. I know it was mentioned someone was working on the front doors because they wouldn ' t lock. Resident #1 was often seen near the exit doors and that ' s why she had on a (brand name) bracelet. She also stated multiple times she had to, or was going to leave because she had to go to work for the government. "
An interview was conducted with Nurse #8 on 2/4/16 at 2:00 PM. She staed she was the 11 PM-7 AM care nurse for Resident #1 on 1/4/16-1/5/16. She stated, " When we got here that night, she (Resident #1) had come down the 600 Hall and into the nursing station to put chairs together. She stated she was going to sleep there that night. About 11:30 PM she (Resident #1) said she was going to get ready for bed. When I was doing my rounds and checking my patients I got a phone call from a lady saying one of our residents was at her house. This was about 12:20 AM. When she (Resident #1) got back she didn ' t have her (name brand) bracelet on. I don ' t know what happened to it. When she (Resident #1) came back she had on some night clothes. A silk jacket and a silk nightgown. She had no shoes or socks on. She was always talking about going home, and we all the time kept up with her because she was always trying to get out. She ' d go to the front door to try to get out. With the (name brand) bracelet on we knew the doors would automatically lock. You know, she

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successfully got out another time, but we got her back in. And the night she eloped the front doors weren ' t locking properly. Every time I come to work I have to punch a code in to unlock the door. The night she eloped I didn ' t have to enter a code because the doors weren ' t locked. I arrive to work between 10:45 PM and 10:50 PM. "
An observation was made on 2/4/16 at 3:00 PM of the front doors to the facility. A resident with a (name brand) bracelet on was wheeled towards the exit door and the door was observed to automatically lock when the resident was within 10 feet of the door.
On 2/4/16 at 3:00 PM through 2/5/16 at 10:00 AM validation of the corrective action plan, submitted by the facility administrator, was reviewed.
· A (brand name) bracelet was placed on Resident #1 when she returned to the facility on 1/5/16.
· All residents with a (name brand) bracelet in place were checked on 1/5/16 by licensed nurses to ensure the (name brand) bracelet was in place and functioning properly.
· The maintenance director came to the facility upon notification of the elopement and checked center doors for proper functioning on 1/5/16. Doors were found to be in compliance.
· The following day, 1/6/16, the vendor who services the doors was brought in and while the doors were found to be functioning properly they adjusted the programming mechanism of the door to ensure that it locks from 8pm to 6am.
From 1-5-2016 to present, facility has not had any issues with (name brand) bracelet function and placement, security of doors, and no residents have displayed exit seeking behavior.
· A review of the maintenance logs for 1/5/16 through 1/16/16 revealed weekly tests by the maintenance department of all fire and exit doors

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for proper operation. No concerns were identified.

· In-servicing began with all staff on 1-5-16 and continued until all staff received in-service training prior to their next scheduled shift 1-7-16.The nurse who did not place the (name brand) bracelet back on identified resident after return from hospital, was reeducated 1-5-2016 on ensuring that a (name brand) bracelet is placed back on the resident when they return from an external location. This nurse as well as other licensed staff were also reeducated (1-5-16 through 1-7-16) on how to identify residents at risk for elopement, what behaviors that may constitute an elopement risk, how to determine if a resident needs a (name brand) bracelet placed and where to find a (name brand) bracelet, how to apply it, how to document it in the electronic medical record system so that placement and proper functioning every shift can be validated. However, it needs to be noted that employees ' were not permitted to work until they received this education. Licensed staff were educated on completing elopement risk assessments upon admission, checking function and placement every shift, how to utilize a secure care tester, where this device is located, the process for removing an ineffective (name brand) bracelet to include placement of a new one, how to manage exit seeking behavior and measures to take if a resident is unable to be located. Staff in other departments were reeducated (1-5-16 through 1-7-16; please note that staff was not allowed to work their next scheduled shift until re-education had been completed) on (name brand) bracelets, identifying behavior that may be considered as an elopement risk, what to do if a resident appears to be attempting to remove their (name brand) bracelet, and what to do if they identify a resident attempting to elope to include immediate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345268	A. BUILDING _____ B. WING _____	C 02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MARSHVILLE	311 W PHIFER STREET MARSHVILLE, NC 28103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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supervisor notification.
· Center doors auditing began 1/5/16 and continue to be audited daily to ensure proper functioning by nursing staff.
· Maintenance has been conducting weekly audits of the doors since 1/5/16. Moving forward until deemed no longer necessary by the quality improvement committee doors will be audited daily to ensure proper functioning by maintenance and/or nursing.
· Beginning 1/5/16, and occurring weekly, the quality improvement committee will review daily audits. This will continue for three months. If after three months of daily auditing, no issues were noted the door audits will then move to being done weekly which is normal center practice. At the time of this incident, 1/5/16, the center instituted weekly audits of residents with (name brand) bracelets conducted by administrator and/or nursing administration. No issues were noted. Center will continue to conduct weekly audits until deemed no longer necessary by the quality improvement committee. Administrator or designee will continue to audit the residents requiring a (name brand) bracelet for an additional four weeks. If after these additional four weeks the center is found to be in compliance then center will allow the process of checking function and placement every shift by the nurses to continue.
· An interview was conducted on 2/5/16 at 9:05 AM with NA #7 and she was able to describe the elopement training and protocol.
· An interview was conducted with Nurse #9 on 2/5/16 at 9:15 AM and she was able to describe the elopement training and protocol.
· An interview was conducted with the DON on 2/5/16 at 9:20 AM and she was able to describe the elopement training and protocol.

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F 323	Continued From page 13 · An interview was conducted with facility administrator on 1/5/16 at 9:37 AM. She staed, " I expect in-services to be held annually, and as issues come up in the facility. I expect competencies to be done at hire and annually. If a resident elopes, we will conduct a search if the entire facility first, then we search the grounds, notify the police, family, and physician. When the resident returns they receive a complete body assessment, we notify the family and physician, and the resident is sent to the hospital if needed. My expectation going forward, if there is another elopement, is that we act immediately using the procedures in our manual. We will make sure the doors are checked, and we need to put interventions in place like a (name brand) bracelet, care planning 1 on 1 observation, sitters, anything we can to prevent cognitively impaired residents from eloping. We need to get the family involved too by encouring frequent visits, maybe a home visit, anything to keep a cognitively impaired resident from attempting to leave. We also need the nurses to tell us immediately if any exit seeking behaviors are noticed so we can put preventive measures in place. We have educated staff on re-placing the (name Brand) bracelet when a resident returns from going out of the facility, and we will continue to educate them. We are also looking at not removing the (name brand) bracelet at all when a cognitively impaired resident goes to the hospital. There really isn ' t a need to remove them. "	F 323		